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## *MANAGEMENT OF PULMONARY TUBERCULOSIS

*by*

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Rapid strides have been made in the treatment of Tuberculosis in the last 15 years. The introduction of wonder drugs has brought forth fresh hope to the sufferers. But at the same time these newer drugs have brought other problems as well. While these anti-tubercular drugs are powerful additions to our armamentarium, their limitations like toxicity, drug resistance etc., pose new therapeutic problems. The ease of administration of the drugs is responsible for a lot of abuse of these drugs. In spite of these drugs, the fundamental basis of treatment of Tuberculosis still remains the same. The advent of chemotherapy has not abolished the need for institutional care for active disease. Bed rest, fresh air, nourishing diet and graded exercise still form an integral part of treatment.

The first essential in the treatment is to establish a correct diagnosis. Patients and physicians are now so tuberculosis conscious that time and again we have seen any shadow in the lung being treated as Tuberculosis. Complete investigations should be carried out to establish the diagnosis. A proper history and the symptoms may warrant the suspicion of tuberculosis. Physical examination of the chest may elicit some signs and a Radiological examination may show some shadows in the lung fields suggesting tuberculosis. But the diagnosis should not be made on these alone. Laboratory studies of sputum or laryngeal swabs or gastric lavage are essential. These may have to be repeated several times. It may be necessary to do Tuberculin tests also. Serial X-Rays, Tomograms, Bronchoscopy and Bronchograms may have to be undertaken to arrive at a proper diagnosis.

Having established the diagnosis of Pulmonary Tuberculosis a proper plan of treatment should be adopted. It is well to remember that Tuberculosis in the majority of our patients is a chronic disease calling for a long term treatment. Tuberculosis cannot be treated completely in a short time. It is also well to remember that in such a pleomorphic and unpredictable disease as this, there can be no rule of thumb approach. Treatment will have to be individualised in every case. Nevertheless a few general remarks on the proper management of patients with Pulmonary Tuberculosis can be made.

The objectives to be kept in mind in treatment are (1) permanent healing of

* Lecture delivered at the Tiruchy Branch of I. M. A. on 27—7—57.

the lesions and (2) minimal loss of function.

1. **General:** Bed rest. Although chemotherapy has shortened the period of bed rest, yet bed rest as part of the therapy especially for febrile cases is as important as ever. The beneficial effects of bed rest are (1) avoidance of muscular effort (2) relaxation of the elastic tension of the lung (same as happens in collapse therapy) (3) a rise in the resting level of the Diaphragm. During this period of bed rest, all investigations could be completed and any complicating diseases such as helminthiasis, anaemia, malaria etc., can be treated.

Institutional or home treatment is the next question. If the home conditions are favourable and satisfactory and if the patient can afford it, bed rest can be arranged at home. But for the vast majority of our patients the home conditions are not favourable and therefore they have to be cared for only in institutions. This is recommended for another reason also. A patient is not likely to rest adequately in the environment with which the onset of his disease is associated. Removal from the scene of his conflict is very helpful in ensuring mental rest. This incidentally removes the source of infection to other members of the family especially the children. In the institution a regular and disciplined life with emphasis on personal hygiene is possible which is difficult to attain in the house.

As regards diet, there need be no great change in the one that the patient has been used to all his life. A slight rearrangement is all that is necessary keeping in view that the Katabolic processes of Tuberculosis should be met with adequate caloric intake.

Bed rest should not be unnecessarily prolonged. As soon as possible after the subsidence of toxic symptoms, gentle exercise and methods of rehabilitation which do not call for too much physical exertion should be started and progressively increased.

2. **Drug Treatment**: Chemotherapy has had varying fortunes. Unfortunately so far no drug has been found which can cure Tuberculosis with certainty. Early research was confined to certain dyes, acridine orange and methylene blue. Later heavy metals like gold, copper, mercury, arsenic, cadmium etc., were in vogue. Of these only gold salts were popular and held the field the longest. These drugs were supposed to stimulate the reticulo-endothelial system and increase the immune forces of the host.

The sulphonamide era 1935–45 may be said to be the beginning of the modern chemotherapy. The sulphonamides were of no value in the treatment of Tuberculosis. The sulphones, especially, Promizole, Promine and Diasone attracted some attention. Thiosemi-Carbazones were found to be very toxic.

The introduction of Streptomycin in 1944 provided the first really effective antibacterial therapy in Tuberculosis. It is both bacteriostatic and bactericidal. It is rapidly absorbed from the intramuscular site of injection and reaches peak plasma levels in about half to three hours. It is poorly absorbed from the gastro-intestinal tract. Its diffusion into the pleural fluid and Cerebro Spinal Fluid is slow and limited but it diffuses well into joint fluid, pericardial fluid, ammiotic fluid and foetal plasma. It is excreted through the kidneys rapidly, 74% in 24 hours.

The disadvantages of this antibiotic are resistance and toxicity. Drug resistance is now got over by using drugs in combinations. The Streptomycin resistant bacilli are pathogenic in contrast to Isoniazid resistant strains.

The toxic effects are damage to vestibular apparatus if Streptomycin is used, and to the auditory part if Dihydro-Streptomycin is used. Other toxic manifestations are skin rashes, drug fever, conjunctivitis, pain in the joints, Eosinophilia. There may also be albuminuria, haematuria, vomiting etc. Contact dermatitis may develop in Nurses and Doctors who handle this drug with hands unprotected by gloves.

But with the present dosage of 1 gm. biweekly one rarely sees these complications. We have not seen any contact dermatitis.

Para Amino Salicylic acid was first introduced by Prof. Lehmann of Sweden in 1946. He showed their tuberculostatic activity in vitro. Para-amino Salicylic acid is available as a pure compound in acid form and as a Sodium or Calcium salt. P. A. S. has no antipyretic properties. It does not produce Salicylism even in large doses. It is absorbed readily from the gastro-intestinal tract. It diffuses freely in the pleural fluid but does not enter the Cerebro Spinal Fluid. It is readily excreted through the kidneys. Its tuberculostatic activity is inferior to that of Streptomycin or Isoniazid. Development of drug resistance is slower compared to Streptomycin. The undesirable toxic effects are chiefly on the gastro-intestinal tract due to irritation. Anorexia, nausea, vomiting, epigastric pain and diarrhoea may occur. Jaundice, renal irritation, hypoprothrombinaemia and agranulocytosis are rare but may occur. Gastro intestinal symptoms may largely be prevented by giving the sodium or calcium salt, giving it after meals, and in gradually increasing doses. If necessary Soda Bicarb or aluminum hydroxide gel may be concurrently administered. P. A. S. is given in doses varying from 10 to 20 grams per day.

Iso-Nicotinic Acid Hydrazide or Isoniazid, holds the pride of place in the anti-tuberculous chemotherapy. Its potency is as good as that of Streptomycin. It has a wide margin of safety. It is the only anti-tuberculous drug which rapidly diffuses into the Cerebro Spinal Fluid and penetrates the monocytes (macrophages). It is rapidly absorbed by the gastro intestinal tract. Organisms resistant to I. N. H. are shown to be a virulent and therefore non pathogenic. I. N. H. is both tuberculostatic and tuberculocidal. The normal daily doses of I. N. H. is about 150 to 300 mgms per day.

The toxic effects of I. N. H. are muscular irritability (convulsions) paraesthesias, mental depression, euphoria, inability to concentrate, loss of memory, visual and auditory hallucinations. But these are not frequent.

Since it is clear that used singly all these drugs are capable of introducing bacterial resistance, they are now used in combination. These drugs are synergistic to one another and it is practically mandatory to use them in pairs. This combined treatment should be used in rotation. The combination of Streptomycin and I. N. H. appears to be the most potent from a tuberculostatic point of view but the combination of I. N. H. and P. A. S. is the best from the stand point of avoidance of drug resistance. The most favoured regimen now is to give Streptomycin 1 gram twice weekly and I. N. H. 100 to 300 mgms or P. A. S. 10 to 12 grams daily.

Viomycin is sometimes used in patients who have become Streptomycin resistant. But this is a very toxic drug. Viomycin is very much expensive than Streptomycin and the injections are also very painful. Pyrazinamide and Cycloserine are two of the newer drugs which are still under investigation. Certain surface active agents triton A – 20 is another new drug awaiting trials.

Chemotherapy should be continued ordinarily for 18 to 24 months. The duration of therapy is determined by the patients X-Rays, E. S. R., Sputum, fever etc. All these should be normal and the lesions well stabilised for atleast three months before these drugs can be safely stopped.

In most cases the drugs give only a temporary stability. Response to chemotherapy is good in minimal lesions, in acute exudative disease and in recent spreads in chronic disease. When an active lesion has not responded to bed rest and chemotherapy in 12 to 16 weeks, surgical treatment has to be considered.

**Surgical Treatment**: Surgical treatment of Pulmonary Tuberculosis has made rapid strides in the last one dacade. This is mainly due to the advances in Radiology particularly body section radiography whereby lesions can be accurately localised, refinements in anaesthesia, blood transfusion to replace blood loss and combat shock and the introduction of potent antibiotics to control infections. Surgical treatment is broadly classified into two groups. (1) Collapse Therapy and (2) Resection.

Collapse measures are again subdivided into revocable procedures and irrevocable procedures. The revocable procedures are (1) Artificial Pneumothorax which is seldom used now a days. (2) Temporary phrenic paralysis which has been given up altogether and (3) Pneumoperitoneum.

The irrevocable procedures are Thoracoplasty and Plombage. Thoracoplasties are no longer the deforming operation they used to be. Modifications in technic are being sought after constantly.

Extra pleural Plombage operations are used in some cases especially in bilateral apical cavities where bilateral Thoracoplasty cannot be undertaken. Various plombage materials are used like Lucite spheres, Polystan sponge and Polythene pack.

Resection surgery consists of Pneumonectomy for totally destroyed lung or Lobectomy or segmental resection. These are used increasingly in modern institutions.

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# *SURGERY IN THE AGED

*by*

**Dr. C. K. PADMANABHA MENON,** M. S., F. R. C. S.

SEVERAL factors make the surgical diagnosis and treatment in the aged, sometimes difficult and in some instances even disastrous, unless certain peculiarities common to the age groups are particularly borne in mind.

As age advances the arteries get sclerosed. Diabetes also contributes a great deal to the difficulties in the management in our country. In addition to these two, cancer and other varities of malignant diseases also contribute a good deal to make the problems of surgery in the aged a very interesting, but remarkably taxing one. The recuperative power of those of advanced age groups are less than that of the robust younger age group. The power of resistance againsts infection is also much reduced. Senile decalcification makes them very much vulnerable to minor trauma with the result fractures occur commonly in them. With the slightest illness prolonged recumbency is almost investiable in many conditions and this will add to the risk of hypostatic pneumonia. Failure of urinary function, recumbent calculus formation and asthenia associated mental changes which are the result of cerebral vascular degeneration, associated monopausal changes which are the result of atrophic changes in the testes and ovary and in many instances associated changes in the myocardiam and coronary vessels and also degenerative changes in the liver and kidneys. Those several factors make it difficult to estimate the prognosis of surgical intervention in patients of the advanced age group. Deminished vital capacity and emphysema add to the magnitude of the problem.

The common clinical problems that face to the Surgeon may be classified as :

1. Those associated with trauma
2. Those associated with the diabetes
3. Those associated with vascular disturbances including thrombosis
4. Those associated with senile enlarged prostate
5. Manifestations of malignant disease lesions.
6. Recrudecence of old tuberculous
7. Intestinal obstructions, including external hernia
8. Osteo-arthritis
9. Wound healing and wound disruptions.

1. With regard to the traumatic conditions we know that Colles fracture and the adduction type of sub-capitellar fracture of the neck of the femur are quite common occurrances following usually trivial injuries. The treatment of this is fairly well standardised irrespective of age. These fractures must be reduced and immobilised by appropriate measures ; in the case of Collis fracture, by plaster, and in the case of the fracture of the neck of the femur, by Smith Peterson's pin. The points particularly to be remembered are early movements and early restoration to normal physiological functions, and avoiding complete bed rest as far as possible. There are a number of other fractures also which are liable to occur in the aged but it is not necessary to go into details of this.

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2. **Diabetes :** Diabetes at any age adds to the seriousness of surgical problems, but diabetes in older people adds to the gravity still more on account of the peripheral neuritis and arteriosclerosis. The age of a diabetic has to be calculated as his true calendar age plus age of his diabetes plus duration of arteriosclerosis. The control of diabetes with diet and insulin has made it possible to undertake many operations which previously would have been considered as very hazardous. But in spite of modern improvements that are available in the field of surgical measures, it has to be admitted that diabetes offers difficult problems. The common diabetic gangrene which often may change from dry to moist on account of infection, carbuncles, cellulitis etc, are all surgical conditions which every practitioner meets with and yet if all of us, in retrospect, review our cases we will be surprised to find that there have been a good many cases where everything has been progressing satisfactorily and yet the patient may have died suddenly on account of coronary insufficiency or pneumonic process, or terminal urinary infection which are all too common and which have to be anticipated in any old diabetic patient. It is worthwhile noticing the difference between the older and younger diabetics and also noticing that gangrene is unheard of in the juvenile diabetics where as it is very common in the old diabetics.

3. **Those associated with vascular disturbances and vascular thrombosis :** This is one of the most unpredictable conditions which should always be taken as granted that even though not yet detectable changes have occurred in peripheral vessel, arterio - sclerotic changes may be present in the internal organs quite unsuspected by the clinician. It is quite a common observation that patients who are apparently in good health and who have been going about their business in the usual way suddenly meet with cerebral vascular disturbance or disturbance of coronary circulation at the least anticipated moment. Such moments can be in the midst of a surgical operation and it is not unusual for the blame to be placed on the surgeons when death happens as a result of these unpredictable causes. Senile gangrene is a fairly common occurrence as a result of arteriosclerosis. There may also be changes in the vessels with the resulting aneurysms of the fusiform or saccular type. Instances of sudden abdominal catastrophy as a result of thrombosis of the mensenteric vessels, instances also of unnoticed thrombosis of the veins in the calf or in the pelvis resulting in an embolus in lung or heart or brain also has to be remembered when faced with a sudden catastrophe. Where heart changes are definitely localised and when otherwise the patient's health is good attempts have been made in other countries to resect the diseased part, example abdominal aorta and replace it by suitable vascular graft. I have witnessed such operations in the United States of America in several surgical institutions, but it incurs a considerable amount of expense, and involves team work and co-operation which or yet to come in our country. Vascular thrombosis is particularly common in the aged and anti-coagulant therapy by dicumerol or heparin dependent on the urgency will have to be considered as preventive measures to prevent clot formation rather than curative measures after thrombosis has already developed. One may stress that in this field particularly prevention of complications is much more effective by wise anticipation and necessary measures rather than cure of the complication once they have occured. Surgery of the prostate and of the spleen, and various extensive resections for maligancy are likely to be associated with vascular thrombosis and it will be wise on our part to judiciously use anti - coagulant drugs. But a note of warning is necessary that almost as commonly, haemorrhages

may occur if too much anti-coagulants are used. It is also wise to remember that as the vessels are sclerosed usually, trauma of vessels will make it difficult to arrest the bleeding by the usual physiological measures of clotting, and also to note that ligations of vessels should be done more gently than in the young adults for fear of rupture of the vessels.

4. **Senile enlargement of Prostate** : I make special mention of this condition in the aged because this is one of the commonest surgical problems, its keen competitor being malignant disease of various organs. As the public health measures improve people are likely to live a longer life and one may except to find the number of cases of enlarged prostate and the number of malignancy of various organs to be difinitely on the increase with the advance and improvement of public health measures. It is regrettable that in our country even now many cases of enlarged prostate go on for a considerably long time under various methods of treatment or more often without any treatment until haematuria or complete obstruction to urinary flow or sleeplessness on the part of the patient from his frequent visits from bath room to bed and bed to bath room make life almost unbearable. In such advanced stages kidneys have already started to show signs of failure. Prostatectomy as a one stage measure will have to be replaced in most instances by two stage prostatectomy in the more favourable cases and supra public cystostomy alone in the unfavourable cases. In our country the old Freyer's method or its slight modifications by a one stage or two stage is still the commonest procedure adopted by the vast majority of surgeons. There are still a good many points to recommend this operation and it will be the method of choice until the medical practitioners and patients come to a more unanimous understanding. The best diagnostic measure is to estimate the residual urine and a quantity of more than two ounces should be immediately considered as serious one and the patients should be advised to undergo prostatectomy. If there is no gross infection of the urine and if the renal function is satisfactory one stage supra public route is the ideal measure. At this stage it is necessary to point out that in diabetics as far as possible the prostate should be removed in one stage. Otherwise the supra public cystostomy is liable to produce a certain amount of sepsis and consequent fibrosis may make it more difficult for the second stage of prostatectomy.

I would discuss the problem of malignancy of prostate as in some cases it may not be easy to decide before operation whether a prostate is malignant or not. Whenever the enucleation of prostate is extremely difficult malignancy should be suspected and a portion removed for biopsy. It is well known that in the ordinary senile enlarged prostate, enucleation is very easy. Its removal may sometimes be in two or three pieces owing to the enormous size. The fibrous and the malignant prostates are usually smaller. With a little experience it is possible to make out the difference quite easily. In such cases a bit can be removed for biopsy and eneucleation discarded. If the biopsy proves malignancy or if from the beginning the case has been suspected to be malignant from reliable clinical findings the procedure of choice would be.

1. Bilateral orchidectomy

2. Stilbesterol (5 mgms. three times daily after checking up tolerance of the drug) reduced to the optimum dose after clinical trial

3. If there is difficulty in passing urine, supra pubic cystostomy which may have to be in some instances a permanent measure.

5. **Manifestations of malignant disease:** Malignant disease particularly carcinoma seems to be the penalty which long life has to pay. Carcinoma of the stomach takes the pride of place in the male (30 per cent) carcinoma of the cervix-uterus and breast seem to vie with each other for the pride of the place in the female. Carcinoma of the rectum and recto – sigmoid account for almost 75 per cent malignant growth of the return. Hyper-nephroma is the malignant growth commonly seen in the kidney in the aged. Carcinoma of oesophagus is a disease of the aged, although in most of these there are some exceptions. In addition to these carcinoma of the lung, carcinoma of the prostate (as already referred to) are all common enough in the older age group. The treatment of malignant diseases cannot be entered into at a great length here, but for any useful surgery the diagnosis must be made comparatively early. It is well known that carcinoma of the rectum and carcinoma of the stomach as well as hyper nephroma can remain symptomless for a considerably long time. They can also remain without any wide dissemination for a quite long time. Therefore it is possible to hope for some small percentage of complete cures and a greater percentage of comparative comfort by earlier surgery in all these cases. The pit-falls in the diagnosis of malignancy are procrastination and delusion of oneself or one's patient by not giving the full significance to the common symptoms like bleeding from the rectum or stomach or lungs or haematuria. If the significance is under stood and if every case is fully investigated by comparatively simple and reliable investigations like rectal examination, sigmoidoscopy, FTM, bariam meal, bariam swallow, I. V. pyelography, a good many cases of malignant lesions can be detected early enough and in time to warrant useful surgery. If for some reason or the other, the early stage is lost sight of, then the problem of malignant disease becomes a very difficult one and often a hopeless one. Carcinoma of the cheek, lips, and tongue and palate are sometimes seem in comparatively young people. They are to a great extent preventible when certain habits like chewing tobacco, smoking with burning end of inside the mouth are all avoided. All the same once these diseases are detected the combination of irradiation and surgery in suitable cases will give a good percentage of cures. But it is necessary to stress that earliar detection by biopsy in doubtfull cases and effective treatment by a combination of the various specialists in surgery and radio therapy will go a long way to the amelioration if not complete cure of malignant disease.

6. **Recrudecense of old tuberculous lesion :** Recrudecence of old tuberculous lesion is often forgotten. This is the point which has to be remembered and a careful history taking will very often be sufficiently rewarding. I have seen a number of cases in comparatively older people where the disease was a tuberculosis but treated as malignant disease and a few cases vice versa also. In secondary deposits in the vertebrae age has very little significance. We must depend on other factors and not on the age. The presence of paravertebral abscess will be a point which will be helpful in the defferenciation and careful examination will always reveal some of the points to confirm the diagnosis of the tuberculosis and exclude the possibility of other conditions. I have not referred to other sites of tuberculous lesion but tuberculosis in the ileocaecal region and tuberculous glands in various parts of the body are not quite so uncommon in the aged as one is lead to believe.

7. **Intestinal Obstruction** *( including external hernia)* : I wish to make a special mention of this condition because there are several mechanical conditions which

are more commonly seen in older persons. Certain vascular disturbances are also seen in the older age group and certain paralytic disturbances are more often seen in the older age group than in the younger age group. Paralytic ileus as a result of diabetic coma uraemia, extreme degree of avitaminosis are very common. Volvulus particularly of the sigmoid seems to be disease of old age. Some of these may be strangulated and others non-strangulated. Careful watch is necessary to distinguish these two. Persons with intestinal obstruction in the older age group do not present very acute symptoms in the beginning as most of the obstructions are either low down in the small intestine or in the colon. Therefore colicky pain and vomiting are both rather late in their appearance. Distention of the abdomen with inability to pass flatus and constipation are the usual symptoms. These, the patients do not take much notice of it as they have been long accustomed to constipation in a milder way on account of the atony of colon usually met with in the older age group. The after effects of syphilis also has in some instances been responsible for producing a certain types of intestinal obstructions. Gall stone ileus is proverbially well known but not detected as often as may be expected, from the importance given to it in text-books. In all these cases intestinal decompression, restoration of the fluid balance and electrolytes are very essential just as much as in other age groups but the possibility of acute dilatation in the heart should be remembered. Over infusion or too rapid rehydration and too much infusion of sodium chloride should be avoided.

8. **External Hernia** : Many of these are Inguinal, some umbilical and a few femoral. Strangulation or at least obstruction is fairly common. The hernia may be long standing. Hence in large inguino scrotal hernia, reduction into the abdomen should not be invariably thought of. In fact in some instances it is better to relieve strangulation and leave the contents in the sac. Repair of the hernia in many cases simultaneous with relief of strangulation may be dangerous. Resections are best avoided unless there is very dire necessity. Strangulation can occur in certain varieties of direct hernia also.

Bad cough, and poor pulmonary reserve are the common accompaniments and so post operative course has to be carefully watched. Same is true of urinary complications also.

9. **Osteo - Arthritis** : This is an unfortunate condition with which patients come, unfortunate because patients are expecting a good deal of help from the Doctors owing to the seriousness of their disability, but the doctors themselves are not able to do very much for the cure of the disease. It is a degenerative condition aggravated by any unusual wear and tear with the resulting stiffness caused by hardening and roughening of the ligaments, irregularity of articular surfaces and new borne formation making movements of joints painful and limited. Some patients develop this disease in the knee joints only. But others are more unfortunate with involvement of the spine and almost every other joint to a greater or less degree. For such widespread lesions very little can be done, but in a few instances lessening of the weight of the patients, lessening of unusual wear and tear by suitable changes in the occupation wherever this is possible and in certain cases where disease is limited to a few joints, deep X-ray treatment in competent hands has proved useful. It has to be remembered that the disease is progressive and the results are not encouraging either to the patient or to the doctor.

10. **Wound Disruption** : This is a definite danger. The best way to avoid

it is to anticipate it in debilitated people. The major factors responsible are,

1. Hypoprotenaemia

2. Vitamin deficiency

3. Infection.

These should be corrected or prevented by adequate preoperative preparations and careful postoperative measures.

I have made an attempt to summarise a few of the common conditions that surgeons have to face in the aged persons and some of the factors to be reckoned with in order to make surgical interventions safe and useful for the patients. It is not possible to go into greater details but the general principles have been stressed.

It is encouraging to look forward in this field and note that advances in surgery have made it possible to replace worn out structures and to rejuvenate the aged by suitable tissue grafts and to relieve the intractable pains of certain incurable conditions by suitable operative measures on the nervous system. Although some of these are not within practical reach of all in our country we can rest assured that many of these measures have gone beyond the experimental stage and are being tried on a clinical level in many of the institutions in other parts of the world and may well be possible in our country also in the near future.

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# RUPTURE OF THE UTERUS

*by*

**Dr. K. G. JANAKI BAI,** M. B. B. S., D. G. O.

RUPTURE uterus is one of the most serious complications that may occur during pregnancy and labour. In the majority of cases the accident is due to neglect during labour. Rupture of the uterus may take place either during pregnancy or early in labour or after prolonged labour. Rupture during pregnancy may be due to spontaneous rupture during last trimester. Rupture the later months of pregnancy may be due to diseased condition of the uterine musculature or weak uterine scars due to fall or other injuries. In spontaneous rupture the tear occurs invariably in the upper part of the uterus and this is in striking contrast to what occurs during labour when the rupture is limited to the lower uterine segment. The result of rupture in later weeks of pregnancy and also early in labour is to permit the escape of foetus wholly or partially into the abdominal cavity and to give rise to severe intrauterine bleeding. The condition where rupture occurs without any premonitory symptoms is known as silent rupture.

Rupture after prolonged labour may be spontaneous or as a result of operative interference. The factors concerned in rupture uterus are conditions which produce a weak uterine musculature like fatty degeneration sypgilis pressure necrosis due to prolonged labour, scar from previous caesarean operations. The mechanical causes are those which produce a relative disproportion between the foetus and the pelvis. Rupture occurs also due to attempts at artificial delivery before the cervix is sufficiently dilated or when uterus is tonically contracted. The improper use of ecbolics such as pituitary extract during the course of labour has also resulted in rupture many times.

The tear may be transverse or oblique, may involve the whole wall or only a portion of it, leaving the peritoneum intact. As a result of the rupture there will be a certain amount of intra abdominal bleeding and the foetus may escape partially or wholly into the abdominal cavity. This naturally depends upon the degree of tear and in some cases where an extensive tear has occurred the whole foetus and the placenta may be found freely floating in the abdominal cavity. The external bleeding is never profuse and it may not occur if the presenting part is jammed in the pelvic cavity. When the rupture occurs the presenting part usually recedes.

There are different varieties of rupture namely complete and incomplete. It is complete if all the three coats including the peritoneum are involved. In case of incomplete rupture the peritoneum is intact and only a portion of the musculature gives way. The signs and symptoms of rupture vary considerably. In rupture occuring during pregnancy or labour the patient may experience a sharp sudden abdominal pain and signs and symptoms of shock and collapse intervene. In other cases the patient may complain of some pain and general malaise. Grave symptoms may occur only very late when infection has occurred. In cases of rupture following prolonged labour the patient has been complaining of severe pain and tenderness over the lower abdomen and the contraction of the

uterus is more frequent and even continuous. Patient has an anxious look and is restless and the associated sign of prolonged labour are manifest. At the height of contraction the rupture occurs and the charesteristic picture is complete. There is sharp acute pain with sudden cry from the patient followed by immediate signs of shock and collapse. After the rupture the patient feels a little relieved as the acute contractions cease. The pulse is small and rapid and the patient usually vomits. The presenting part recedes and on abdominal palpation the foetal limbs can be easily felt and the contour of the uterus is changed. If the patient is not immediately attended to the termination are either rapid death from collapse due to haemmorhage and shock or delayed death from peritonitis with septicimea.

The diagnosis of this condition is not very difficult. Occasionally in prolonged labour it may be difficult to decide whether the uterus is threatening to rupture or has actually ruptured. Other conditions with which rupture of the uterus may be confused are concealed accidental haemmorhage and secondary abdominal pregnancy.

Prognosis is bad for both the foetus and the mother. Treatment : The prophylactic treatment for this is by far the more important as with proper care such a catastrophe should not occur. Efficient antinatal care which includes the diagnosis and correction of mal presentations, the recognition of the degree of any disproportion or any defects of the uterus due to previous disease or operation will go long way to ward off the possible occurrence of rupture. The curative treatment depends upon the condition of the patient when seen the condition of the foetus whether the rupture has occurred during pregnancy early in labour or late in labour whether it is spontaneous whether the foetus has escaped into the peritoneal cavity, whether complete or incomplete rupture and also the experience of the obstetrician concerned.

Having gone into the causes and symptoms and diagnosis of rupture of uterus, the usual treatment adopted is as follows : The patient is treated for shock with intravenous saline and blood transfusion etc. before surgery is taken up or treatment of shock etc. are started and immediately or soon after depending upon the condition of the patient, laporotomy is done. Among the methods of treatment if the child is alive laportomy should be immediately performed and after removing the foetus, the uterine tear should be sutured or supraviginal or total hysterectomy should be performed. In rupture due to prolonged labour, the foetus will invariably be dead. If the foetus is dead and rupture has happened after prolonged labour, the ideal method of treatment particularly if the foetus has escaped into the peritoneal cavity is to open the abdomen, remove the foetus and perform a total hysterectomy. The above has been the usual treatment that was adopted in many cases. But an attempt to save the uterus was made in 26 cases in the Gandhiji Memorial District Head Quarters Hospital, Tiruchirapally. In very many cases, the patient happens to be quite young and conserving the uterus seems to improve the patient physiologically and physycologically. Even if they do not have any more children, it makes them feel normal otherwise. Hence the attempt to repair the uterus. During the years 1954–55 and 1956, 26 cases of rupture uterus were treated in the hospital. In all the cases admitted, the rupture has occurred prior to admission and were brought in a collapsed condition and no time was lost in diagnosing the condition. As soon as the diagnosis was made the patient was treated for shock and collapse with blood transfusion etc. and prepared for laporotomy. After opening into the abdomen the foetus with the placenta is removed

and the ruptured part of the uterus is sutured in layers even if the tear is irregular and the musculature damaged extensively and after that the abdomen is closed in layers. Most of the rupture were found to be transverse at the lower uterine segment and few " T " shaped extending down to the vagina. Total hysterectomy was done only in 3 cases out of the 26 cases referred to. On review we find that repair of the uterus can be done with safety in cases of rupture of the uterus and the post-opertive complications also are very much lessened especially in these days of antibiotics. We have not sterlised all the cases of rupture that were admitted in the hospital owing to the collapsed condition of the patients. So much so two of the old cases of rupture came with advanced pregnancy and on whom classical caesarean section with sterlisation was done. They have done well without any post operative complications and had an uneventful recovery. So our experience in the hospital is that it is possible to suture up the tear of the uterus that has occurred after a prolonged labour due to bad handling outside and also after injections of pituitrine even though the tear is irregular and musculature is badly damaged.

Most of our cases were brought to hospital from mofussil stations in a complete collapsed state and so could not stand an immediate laporotomy with hysterectomy. Even the question of giving anaesthesia was risky in some cases, and so we had to resort to local anaesthesia.

The following is an extract of a journal Lapreisa medical. Conservative treatment of ruptured uterus by Trander de saigon Hysterectomy may have saved the life of many a women suffering from uterine rupture, but it was to avoid such a mutilating operation as hysterectomy whenever possible and to preserve the possibility of reproduction especially in young women. That was the author's concern as expressed in this paper. He treated in a conservative manner by sutures 23 cases of rupture out of 163 cases operated on for this severe accident. Of these 23 sutured only one fatality was observed. Of the 140 hysterectomy cases 24 fatalities occurred. Such a difference is explained by the fact that the cases which were to be treated by suture had been cautiously selected. Among the 23 sutured cases the author divided and ligatured the fallpoian tubes in 12 cases and kept the function of reproduction in the remaining 11 cases. Of the later only a smaller could be followed up. Two women were seen to be pregnant again and to be normally delivered. Another is seen to be pregnant six months at the present moment.

The author considers such results encouraging and emphasising the extend of a conservative treatment of ruptured uterus wherever possible.

# VITILIGO

*by*

**Dr. T. V. VENKATESAN,** M.B.,B.S., F.C.C.P., F.D.S.

*Honorary Physician, Erskine Hospital, Madurai.*

VITILIGO or Leucoderma is a disorder of melanogenesis. There are patches of dead-white colour with sharp normal or hyperpigmented edges may be seen. The etiology is still unsettled.

**Pathogenesis:**

The colour of the normal skin is due to a variety of pigment of which melanin plays an important part. There are 3 phases in melanin pigmentation of the skin.

1. Pigment darkening takes place under the influence of radiant energy.
2. Migration of pigment occurs to superficial layers of epidermis after exposure to U. V. Rays.
3. Formation of new melanin or melanognesis.

The enzyme tyrosinase, a copper protein is present in the pigment layer of skin attached to mitochondria. The amino acid tyrosine is the precuursor of melanin and the conversion is helped by tyrosinase.

**Histopathology in Vitiligo:**

The epidermis is devoid of pigment, otherwise remains unchanged. In the surrounding regions the epidermis is hyperpigmented and the appendages are surrounded by branched hyperpigmented cells.

Meladinine when applied externally and given systematically produces repigmentation. It is a psoralene drug containing ammoidin, ammidine and majudine, Ammodin initiates repigmentation. Ammidin accelerates it and stops development of new patches while majudine fixes the new pigment and makes the reaction irreversible.

For local application the meladinine paint is diluted. The solution is diluted with 60% alcohol and $\frac{1}{8}$ strength is used for the first few days and gradually increased to $\frac{1}{4}$ strength. After application the patches are exposed to Ultra Violet Rays.

To enhance the action oral tablets in dose of three tablets per day are given. The strength of the oral tablets :—

Each tablet contains 10 mgms of Ammoidin and 5 mgm of ammidine.

The solution contains per c.c. 7·5 mgm of ammodin and 2·5 mgm. of Ammidine.

Since the tablets are toxic a periodical check up of the following are sine qua-non.

(1) ESR (2) Total WBC and DC (3) Urea contents of blood (4) Urine examination for Albumin and sugar.

The duration of the treatment depends on there sponse. On the average about two months are required.

Instead of Ultra-Violet Rays, sunlight can be used.

A histological technique and a dopa reaction are helpful in classifying the types of Vitiligo.

**They are:**

1. Dopa positive are absent.
2. Relative type 1 in which the melanocytes are slightly Dopa positive but are present in normal numbers.
3. Relative type 2 in which the number of Dopa positive melanocytes are reduced.

The relative types are only the forerunner of the type I or absolute type.

Comparitive results between Solar-irradiation and Ultra-Violet Rays after Meladinine painting has shown that the Solar Irradiation showed a better response than Ultra-Violet Rays.

# * SOME FUNCTIONS OF THE SYMPATHETIC AS YET UNDISCOVERED

*by*

**Dr. K. C. NAMBIAR,** M.S., F.R.C,S. (ENG.), F.R.C.S. (EDIN)

*Hon. Surgeon, Stanley Hospital.*

I have been observing certain phenomena as early as the year 1928, and have been working on them ever since by clinical and physiological observations upon myself, my colleagues, some students and patients and have come to the following conclusions. The experiments conducted were not on the laboratory scale, because they involved observations on human beings only, in wards and everyday life. This will show that much could be done by observation and criticism in the absence of a test-tube or microscope. I might also state that these observations are entirely of an original type and have drawn no inspirations from any other person or work.

1. The first thing I noticed was that on lying in bed on the left side, the ventilation of the left nostril was absent or deficient, when compared with that on the right side. And lying on the right side showed deficient air entry through the right nostril. I first conjectured, that the capillaries on the dependent nostril contained more blood and therefore the lumen was narrowed. This obstruction was more prominent when the person was the victim of a common cold, probably, the congestion being unusually great. But I soon discovered that the theory of passive venous congestion was untenable ; for, if the head is kept much lower without any pressure on the chest-wall this phenomenon of blocking doesn't arise. Meanwhile a surgeon of the city suggested to me that the blockage may be mechanical due to pressure on the Jugular vien, as when lying on a particular side. But this could be easily proved to be false, as direct compression of the Jugular on one side does not give rise to this phenomenon.

2. I observed again that, on crucially examining the ventilation of each nostril at different times of the day, the amount of air entry was found to vary from side to side, even in the erect position of the body, the time for alternation of activity from side to side being approximately 1½ hours not by any chance, accurately so. This alternation of activity I now under stand, that our Yogi-students of yore, were perfectly aware of. It was so strikingly interesting to me, that even our great physiologists have never noticed this alternation of respiratory ryhthm, at the same time, going or breathing in this fashion 24 times a minute, all through their lives. The reason of such is obvious. Because, today, we are not able to comprehend research and discoveries, as isolated from test tubes and microscopes. I believe, a lot more, still, can be done, by way of research through personal analysis and criticism.

3. Later on I made another useful observation, which gave me a clue to the causation of such alternation in the rhythm of breathing. I lay on my back with no inclination to the right or left and pressed on one side of the chest by

* Reprinted from Journal of the Stanley Medical College.

means of a pillow. It was seen in a few minutes, that the weighted side showed comparative nasal obstruction. So it became clear that neither the gravity on the dependent part, nor the unilateral obstruction to the Jugular vein could have produced the above type of nasal obstruction. At this stage of my findings, a rather attractive suggestion was given to me by a reputed physician in Madras. He was of opinion that there were two different streams of air from either lung, not freely mixing with each other in the air passages ; and therefore these streams came out through the homolateral nostril. So when lying on, or when pressure is applied to one side of the chest, the latter side of the lung is partly out of action ; and therefore the current on this side is comparatively weak and the air entry through the same nostril is weak or absent. At first thought the suggestion was rather promising ; but I soon discovered that the explanation could not stand. For one reason, it is difficult to imagine, how these currents could avoid mixing in a narrow windpipe ; and secondly, my experiment on a patient on whom, a complete internal thoracoplasty was done by Lt. Col. Pandalai, I.M.S. proved the inadequacy of the explanation. Pressure was applied to his chest manually, as well as by making him lie on either side ; and the usual results were obtained, though his lung was completely collapsed on one side. Hence it struck me that I should look for an explanation, in some sort of a nervous relation between the chest and the bloodvessels of the nasal mucosa. For a time, I tried to implicate the Vagus, the Sympathetic and the Intercostal nerves, in vain.

4. Further experiments were carried out by me to elucidate this point. The mechanical stimulus of pressure was replaced by thermal and tactile stimuli, with no change in the nasal ventilation. Therefore the afferent path didn't arise in the skin or chestwall. Again the maximum effect was noticed by pressing in the lateral line of the chest; and especially so in the axilla ; while pressure in front and behind the chestwall showed rather a slow and mild effect in changing the nostril rhythm. What could this difference be due to ? I applied my knowledge of physiology towards this problem. I have already come to the conclusion, that the nasal obstruction was certainly due to an active capillary hyperemia, and not a passive venous congestion of the nasal mucous membrane. Such an active capillary hyperemia could be easily explained by an assumption of the interference of the normal tonicity of the upper sympathetic nerves. Therefore I assumed, that the pressure in the midaxillary line prodnced a distortion in the curvature of the ribs, and thus the head and neck of the rib was slightly pushed forward. As the sympathetic trunk lay in front of the ribheads, it could be expected to interfere with the normal tone of the sympathetic in contracting the peripheral capilaries. Thus vascular dilation results in the mucous membrane of the nose. It could also be seen why the pressure in the axilla has got the maximum effect. The latter distorts the first and second ribs and therefore directly interferes with the stellate ganglion.

5. Starting on this theory not yet proved, I was able to gather many other facts, which could be reasonably utilised as collateral evidence, for the sympathetics being involved, in the above experiments. I found to my great surprise, that the whole of my right side was perspiring including the head trunk and limps, while lying on my left side and vice-versa. It looked to me nothing short of marvel, to be able to change my perspiration from side to side by simple pressure on the chestwall : and many of my friends couldn't believe it until it was proved to them in person. And I could also notice that, normally perspiration varied from side to side, at frequent intervals, in the absence of any pressure on the chestwall.

The most interesting part of it was, that this variation almost corresponded to that in the nose already described. Now that we know, that the act of perspiration is a sympathetic one the latter in relation with pressure on the chestwall, forms a strong collateral evidence, in favour of my theory, regarding the alternation in the nasal rhythm.

6. The case for the sympathetic in the above phenomena is sufficiently strong ; but it lacked direct experimental proof. So, I sought for the most crucial test, clinically and through surgery, better than by vivisection. A patient was selected with circulatory deficiency in one arm, on whom, a stellate ganglion-ectomy has been performed, by Lt.—Col. M. M. Cruickshank, I. M. S., on the corresponding side. His name was Amawasi, aged 30. I examined him a week after the operation ; and the first thing he told me was that, he could not breath through his right rostril, and he had his right stellate ganglion removed. I examined his nasal rhythm and was satisfied that his nasal blocking was certainly due to the removal of sympathetic influence, on that side. The same patient had his left stellate ganglion removed on a later date, and then, again the findings were exactly what I expected. He could breath through both his nostrils, but not so freely as before, the lumen being partly narrowed on either side. Further to my great satisfaction, I discovered, that the change of rhythm brought about by the alternation of unilateral pressure on the side of the chest, no longer could hold good. These experiment prove beyond doubt that the mechanism of the side changes, was through the sympathetic system. It was also noticed, in the case of the above patient, that the sweating on the trunk and inferior extremity corresponded to the side of the pressure on the chest ; while that in the face and upper extremity was very much diminished and did no longer alternate.

Now that it has been proved beyond doubt that the nasal ventilation rhythm is controlled by the sympathetic system, it should be automatically inferred that the normal alternation of nasal rhythm from one nostril to the other can only be due to the alternating tonic capacity of the right and the left sympathetic system. Having established the latter fact, one can theoretically arrive at certain facts of physiological importance, that in the normal individual, the bilateral organs in the body innervated through the sympathetic, also must show this change of alternation of activity. My observations have already shown they do. Now this explanation of mine can also be utilised in the elucidation of certain problems, hitherto observed, but unexplained ; *e. g.* the alternating secretary capacities of the kidneys have long been observed by the urologist and the radiologist ; but no satisfactory explanation could be given to it till now.

Starting from the top of the body, examination of the fundii, at different times, shows an alternating change in the amount of capillary dilatation in eitheir eye. Similar changes taking place in the mucous membrane of the nose resulting in partial obstruction and alternation of the nasal rhythm has already been dealt with. Physicians have always noticed on auscultation of the chest, the air-entry on one side of the lungs preponderating over the opposite side. By ureteral cathetrisation of the kidneys, the urologists have shown the rapidity of secretion from either kidney alternated at different times : also the Radiologist, when taking pictures every 5 mts. after intravenous pyelograme has visualised the alternating opacity of the secreting kidney. And it may be inferred that all other bilateral organs in the body such as the suprarenals and testis also must show this change.

I feel certain that the above facts contribute a good deal and create a new opening in the furtherance of the study of the autonomic nervous system.

# A CASE OF IMPETIGO HEPETIFORMIS

*by*

**Dr. T. V. VENKATESAN,** M.B.B.S., F.C.C.P., F.D.S.

*Honorary Physician, Erskine Hospital, Madurai.*

IMPETIGO hepetiformis is a rare disease it is an inflammatory affliction of skin characterised by the occurence of pustules occurring in groups. They are miliary pustules which occur at periphery of Erythematous plaques. The commonest sites are, the groins, the axilliae, the breasts and about the umbilicus.

Constitutional symptoms are always present and disease becomes grave. The fever may be remittent intermittent or continuous. Vomiting, delirium and diarrhoea may occur.

**Etiology :**

The disease occurs during pregnancy are puerpurium the toxines being held responsible. It has not been possible to demonstrate any indisputable cause.

**Histology :**

The dilatation of blood vessels and cellular infiltration can be seen. These changes can be most commonly seen in the superficial portion of corium. Cocci are found in the pustules and the cellular infiltration has been mostly eosinophils.

**Case Report :**

Mrs. V aged 26 years. First child birth normal. She was pregnant 7 months. The patient was having irregular fever and erythematous rashes with miliary pustules at the periphery.

**Examination :**

Patient apparently anaemic.

The systems revealed no abnormality.

**Lab :**

WBC, 11200, His. 60%

DC P 62 L 21 E 17.

**Urine :**

Albumin and sugar NIL.

**Histopathology skin :**

The epidermis shows a foci of cellular infiltration with dilatation of blood vessels.

**Treatment :**

The patient improved in two weeks with.

(*a*) hydrocortisone ointment externally.

(*b*) prednisolone tablets and one tablet three daily for 7 days and then twice daily for 7 days.

(*c*) Erythromycin tablets one tablet thrice daily for 7 days.

*In all stages of Intestinal Amœbiasis*

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OTHER INTESTINAL INFECTIONS OF VARIOUS AETIOLOGY

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# INDIAN MEDICAL ASSOCIATION

## MADRAS STATE BRANCH

*Extracts from the Minutes of the Council of the Madras State Branch of the Indian Medical Association held at the Municipal Travellers' Bunglow, Chingleput, on Saturday the 21st September 1957 at 1-30 p.m.*

DR. Y. P. VASUDEVAN PRESIDED.

21 MEMBERS WERE PRESENT:

30 members have sent messages expressing their inability to attend the State Council Meeting:

President's introductory remarks: The President said that this was the last meeting of State Council over which he is presiding and thanked the members for their kind help and co-operation extended to him during his tenure of office as President of the Madras State Branch, I. M. A. during the past three years.

He then congratulated Dr. D. V. Venkappa, a veteran member of the Association, on his election as the President of the Indian Medical Association (Central) and paid his tribute to his long period of service and sacrifice.

Dr. D. V. Venkappa, replied to the felicitations, and said that he would on his part do his best to serve the Association as long as there was the spark of life in him.

The following resolution was thereupon passed unanimously: This Council of the Madras State Branch, I.M.A. heartily congratulates Dr. D. V. Venkappa, an old and veteran member of the Madras State Branch, I. M. A. on his election to the high and honoured office of the President of the Indian Medical Association, and wishes him all success in the discharge of his onerous duties."

Condolence Resolution condoling the death of Dr. R. Venkatachary of Virudhunagar, Dr. M. Kalyanasudaram of Madurai, Dr. A. Jabbar of Karaikudi and Dr T. S. Renga Iyengar of Madurai was moved from the Chair and passed unanimously, all the members standing for a minute.

The minutes of the previous Council meeting held at Kozhikkode were adopted.

Members of the Medical Profession and Rent Control Act—eviction proceedings against. Dr. U. Krishna Rau said that there was no regular G. O. on the subject exempting medical practitioners from the provisions of the Rent Control Act. The President explained to the Council that though there may be no regular G. O. on the subject the Govt. were kind enough to give an assurance sometime back that they would consider individual cases on merits, and read out the letter of the Chief Secretary, Government of Madras dated 15—12—1952 on this subject. The Council felt that the matter should be pursued in a constitutional manner and for this purpose as a preliminary measure a deputation of the State Council may wait upon the concerned Minister or such other officials as may be found necessary and represent the view point of the I. M. A. that medical practitioners of certain standing should be exempted from the purview of the Act

and that they should be granted protection from eviction or other execution proceedings. Accordingly the Council nominated the following members to constitute the deputation, and requested them to take further action to achieve the desired results:

1. Dr. D. V. Venkappa, L.M.P., Madras.
2. Dr. M. Santosham, M.B., B.S., F.C.C.P., Madras.
3. Dr. V. Vijayaraghavan, L.M.P., L.O., Madras.

Family Planning—Surgical Methods—Payment of subsidy to private medical practitioners for Vasectomy operations. The Government have in G. O. (Ms.) No. 2047 (Health) dated 11th July 1957 accepted the recommendation of the Madras State Branch, I. M. A. and have sanctioned the payment of subsidy at Rs. 25/- per operation to private medical practitioners authorised to do the operation. The President informed the House that though for the present this scheme is put into force only in the Madras City, if any local branch is desirous of having this scheme extended to its area, a resolution to that effect may be passed and sent both to the State Branch and to the Director of Medical Services in view of the fact that the D. M.S. has called for a list of doctors from the mofussil also.

Improvement of the I. M. A. Organization at Central, Journal and State levels–proposal put forward by Dr. A. P. Mittra, Hony. General Secretary–suggestion to raise the quantum of CFC by local branches from Rs. 8—00 to Rs. 12—00 and reduction of the strength of the Central Council–consideration of: The Hony. Secretary informed the House that he had circularised all the local branches to elicit the views of the local branches on these proposals. Replies were received from some and replies from others are awaited. The local branches who have so far replied are of the view that they are totally opposed to any increase in the existing rate of CFC for members and that regarding representation on the Central Council some branches are in favour of having one representative per each local branch. After some discussion on the subject the Council was of the opinion that the proposals put forth by the Central Office were not opportune at the present moment, that it was not in favour of any increase in the quantum of CFC of members and that as regards reducing the strength of the Central Council this State Branch may perhaps agree that the Central Council should be made a compact body provided atleast one representative is allotted for each local branch in the State.

Circulars of the Indian Medical Association were read and recorded.

Circulars of the Indian Medical Association, Madras State Branch were read and recorded.

Any other item with the permission of the President: Dr. K. V. Swamy (Madras) suggested that it is time that the Madras State Branch I. M. A. thought of acquiring a building of its own for housing the office of the State Branch and for affording other amenities to the members and said that this subject should be given its due consideration. The President observed that there is no fixed place for locating the head-quarters of the Madras State Branch and if a definite decision is taken regarding the location of the headquarters of the Madras State Branch the question of acquiring a site or building can be considered thereafter.

Dr. R. Varadarajan (Chingleput) said that their branch of I. M. A. at Chingleput is facing a peculiar difficulty. He said that the D. M. O. of the place calls for a meeting of all doctors in service which very often clashes with the meetings

organised by the local I. M. A. with the result the attendance at the I. M. A. meetings become very poor. Dr. C. Nathamuni Naidu (Ambur) said that in his district (North Arcot) also the same difficulty is experienced, and that they are trying to merge both meetings into one by gradual persuation etc.. Dr. G. Sriramulu (Madras City) said that this problem is also present in the City of Madras where there is an Association called Madras Medical Association which has its own meetings. He said that if they could be only one Medical Association in a place the attendance at the meetings would be encouraging. The President observed that the situation described by the members did unfortunately exist in some districts, but was confident that this difficulty will be solved gradually with mutual good will and personal contacts. He felt that medical men in official position should meet the private practitioners often at Medical Association meetings and such contacts are essential for their mutual benefit and that the local branches of I. M. A. should endeavour to create an atmosphere for Govt. medical men to be eager to attend the I. M. A. meetings. He also suggested I. M. A. meetings may be held as often as possible in the Hospitals synchronising with their clinical meetings and this will foster cordial relationship.

After a motion by Dr. K. V. Swamy (Madras) the following resolution was passed.

"This Council of the Madras State Branch of Indian Medical Association resolves to request the Government to sanction necessary foreign exchange for post-graduate studies in foreign countries."

Dr. U. Krishna Rao (Madras) suggested that the Madras State Branch of I. M. A. could address the Director - General of Health Services, Delhi, and ask for certain Government publications to be supplied free of cost for the library of the State Branch.

Vote of Thanks.

The following resolution moved by Dr. C. Nathamuni Naidu (Ambur) and seconded by Dr. K. V. Swamy (Madras) was passed unanimously:

"This Council of the Madras State Branch of the Indian Medical Association places on record its high appreciation and grateful thanks for the untiring work and sound guidance of Dr. Y. P. Vasudevan, M.B.. B.S, B.S.SC., as the President of the Madras State Branch, I. M. A. during the three years of his office, and for the moderating influence exercised by him in all matters pertaining to the Association. This Council desires that Dr. Y. P. Vasudevan would continue his good service and guide the affairs of the State Branch in the future as an elder and experienced member of the branch."

The following resolution was thereafter moved by the Chair and passed unanimously.

RESOLUTION.

"This Council expresses its sincere thanks to the Chingleput Branch of the Indian Medical Association for the excellent arrangements made for the successful conduct of the meeting of the State Council of the Madras State Branch, I. M. A. and for the fine arrangements made for the boarding and lodging of the visiting members of the State Council."

The meeting terminated at 3–30 P. M.

**Y. P. Vasudevan,**
*President.*

**C. Arumugam,**
*Hony. Secretary.*

# ASSOCIATION NEWS

## COIMBATORE BRANCH

A monthly meeting of the Association was held on Tuesday the 24th September 1957, in the Association premises. Dr. Sundareswaran, M. B. B. S., L.O. Vice-President presided.

Dr. M. Natarajan, B.A., M.B.B.S., F.R.C.S. (Eng)., Mch. (Ortho)., Orthopaedic Surgeon, Government General Hospital, Madras addressed the members on " The Orthopaedic Management of Poliomyelits."

* / * *

A monthly meeting of the Association was held on Saturday the 28th September 1957 in the Association premises. Dr. T. V. Sivanandam, M. B. B. S.. M L C., President presided.

The following resolutions were unanimously passed.

" This Association congratulates Dr. D. V. Venkappa, L.M.P., Madras on his election as the President of the I. M. A. Central for the year 1957–58 and wishes him successful in tenure of Office.'

" This Association congratulates Dr. A. G. Leelakrishnan, M.B.B.S.. of Coimbatore and Dr. K. Rama Iyer, M.B.B.S., of Tirunelveli on their success in election of the Vice-Presidents of the Madras State Branch of I. M. A. for the year 1957–58."

" This Association hereby resolves unanimously that the existing rate of Central Fund Contribution of Rs. 8/– per annum per head may be continued and is not for the enhancement."

This meeting of the Coimbatore District Medical Association hereby resolves as follows :–

" In view of the difficulties experienced by the Medical Practitioners in securing the essential Drugs like Pethidin, Omnopon, Morphia etc., Anti-Biotics, laboratory chemicals and reagents, X-ray films and chemicals needed in their daily practice, this Association requests the Government of India through the Offices of Central and State Branches of the Indian Medical Association to liberalise the Regulations concerning the imports and distribution of such products so that they may be easily made available for legitimate use by the Medical Profession."

" This Association requests the medical members of the State and Central Legislatures to bring this question to the notice of the appropriate authorities."

Then Dr. P. N. Rangayya delivered a lecture on " Venereologists' Dilemma."

## MADURA BRANCH

The monthly meeting of the Association was held at Christian Mission Hospital under the Presidentship of Dr. K. Balakrishnan, M.B.B.S., T.DD. The Secretary informed the house on the recent Government Amendments to Drugs Act and a resolution requesting the Government to drop the proposal forth-with was passed. Then a resolution requesting the Director of Medical Services, Madras to extend the Family Planning Scheme (Surgical methods) to Madura city was also passed.

Dr. Beatrice S. Chinniah, M.R.C.P. D.Ch. spoke on " Retarded Growth in Children."

## SOUTH ARCOT BRANCH

The Annual Meeting of the South Arcot Branch of I. M. A. was held on Saturday the 21st September 1957 in the District Board Hall, Cuddalore with

Dr. C. Seshachalam Naidu, L.M.P., the President in the chair.

It was resolved unanimously to request the Indian Medical Association not to enhance the C. F. C. and also to have one representative to the Central Council from each local Branch.

The following office-bearers were elected.

*President*: Dr. V. Viswanathan.

*Vice-President*: Dr. S. Sankararaman.

*Hony. Secretary*: Dr. A. A. Shukoor.

*Hony. Joint Secretary*:

Dr. K. M. Venkatachalam.

*Executive Committee Members*:

1. Dr. C. Seshachalam Naidu,
2. Dr. P. Vaidyanathan,
3. Dr. M. V. Lakshmi,
4. Dr. A. Janakiraman,
5. Dr. C. S. Swaminathan.

*Representative to the Central Council*:

1. Dr. K. G. Sadagopan.

*Representatives to the State Council*:

1. Dr. V. Krishnamoorthy,
2. Dr. S. Sankararaman.

*Representative to the Hindu Kushta Nivaran Sangh, Cuddalore*:

1. Dr. Annaswamy Venkoba Rao.

Dr. C. S. Sadasivam, M. S., Professor of Thoracic Surgery, Madras Medical College gave a very interesting lecture on *Bronchiectasis*: Signs, Symptoms and Treatment.

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The monthly meeting of the Association was held on Saturday the 19th October, 1957 in the Y. M. C. A. Hall, Cuddalore.

Dr. V. N. Viswanathan, M.B.B.S., (Dt. Medical Officer, Cuddalore.) spoke on "Pit-falls in Medicine & Surgery".

## SALEM BRANCH

The monthly meeting was held on 27—9—57 in Foulks Hall.

Dr. V. Kuruvilla M.B., B.S., D. M. O. Salem gave a lecture on "Acute Abdomen".

## TIRUCHY BRANCH

The 28th annual meeting of the association was held on Sunday the 27th October 1957 in the premises of the Medical Association Buildings, Salai Road, Woraiyur, Tiruchy. The following Office-bearers were elected for the year 1957-'58.

*President*: Dr. L. S. Ramachandran.

*Vice-President*: Dr. R. Sambasivan.

*Hony. Secretary*; Dr. M. V. A. Iswaran.

*Hony. Treasurer*: Dr. C. R. Chari.

*Managing Committee*:

Dr. V. Ananthagiri,
Dr. M. Balammal,
Dr. I. Chandrasekaran,
Dr. A. Dharmarajan.
Dr. R. Kalamegham,
Dr. P. Palaniyandi,
Dr. T. V. Sundaram,
Dr. P. V. Sundaram,
Dr. S. Venkatesan.

*Central Council*:

Dr. T. V. Srinivasan.

*State Council:*

Dr. V. Ananthagiri
Dr. I. Chandrasekaran,
Dr. A Dharmarajan,
Dr. R. Ganesan,
Dr. R. Kalamegham,
Dr. S. Venkatesan.

The following resolution was passed unanimously.

"The Tiruchy Branch of the I. M. A. feels that the amendments proposed to the Madras Manufactured Drugs Rules, 1932 and the Dangerous Drugs Act are unworkable and will strain on practitioners and hence should not be accepted, but rejected."

Dr. R. V. Rajam, M. S., F.R.C.P., Dr. K. A. Kalyanam. F.R.C.S., D.M.R., Dr. P. Govinda Menon, F.R.C.P. and Dr. M. S. Narayanan, L.M.S., addressed the members on "Doctors, Diseases and the population problem", "Non-malignant diseases of the thyroid", "Diarrhoea and vomitting in children" and "Leukaemias" respectively. The film on "The Multiple deficiency Synrdome in children (Kwashiorkar) and slides on "Complication of Diabetes Mellitus" by M/s. Eli Lilly Co. of India and the film on "Spinal Anaesthesia" by M/s. Ciba Pharma Private Ltd., Bombay were shown to the members.

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The 29th Inaugural Meeting of the Association was held on Sunday the 17th November 1957 in the premises of the Medical Association Buildings, Salai Road, Woriur, Tiruchy.

Dr. L. S. Ramachandra Iyer, MBBS, BSSC., DTM, the President, presided.

Dr. M. S. Ramakrishnan, M.S., Civil Surgeon, Govt. General Hospital, Madras and Dr. K. Vasudevan, M.S., Civil Asst. Surgeon, Govt. General Hospital Madras addressed the members on "Acquired deformitties of the face and their plastic corrections" and "Cortisone and allied compounds" respectively.

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A monthly meeting of the association was held on Saturday the 7th December 1957 in the premises of the Medical Association Buildings Salai Road, Woriur Tiruchy.

In the absence of the President, Dr. R. Sambasivan, M.B.B.S., the Vice-President of the Association presided.

Prof. Dr. Sophus Von Rosen (Professor of Orthopaedics, University of Lund and Surgeon in Chief, Orthopaedic Department, Malmo General Hospital, Sweden) addressed the members on "Treatment of Sciatica".

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A meeting of the association was held on Saturday the 21st December 1957 in the premises of the Medical Association Buildings, Salai Road, Tiruchy.

Dr. L. S. Ramachandran the President presided.

Dr. M. D. Ananthachary, M.D., Principal Madurai Medical College, Madurai addressed the members on "The Basis of Thought Processes".

## ERODE BRANCH

A meeting of the association was held on Saturday the 7th December 1957 in the premises of Erode Medical Supplies Private Ltd.. Erode. Dr. M. S. Narayanan L M.S., Fellow International Society of Haemetologists addressed the members on "The diagnosis and rational treatment of the common anaemias".

## MADRAS CITY BRANCH

A meeting of the association was held on Tuesday the 26th November 1957 in the premises of the Madras Medical College, Madras. Prof. Dr. Sophus Von

Rosen, Professor of Orthopaedics, University of Lund and Surgeon in Chief, Orthopaedic Department, Malmo General Hospital, Sweden addressed the members on " Treatment of Sciatica ".

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A meeting of the association was held on Monday the 9th December 1957 in the premises of the Madras Medical College, Madras. Dr. V. Kalyanasundaram, MBBS, LO., addressed the members on " Blindness and its causes and steps for prevention by the Public, Profession and the State ",

## SOUTH KANARA BRANCH

At the Annual General Body Meeting of the Association held on 4-12-1957 at the District Board Hall, Mangalore, the following office bearers have been elected unanimously for the year 1957-58

*President :* Dr. K. Nagappa Alva.

*Vice-President :*

Dr. (Miss) L. Colaco.
Dr. C. P. Kamath.

*Hon. Secretary and Treasurer :*

Dr. V. R. Bhat.

*Hon. Joint Secretary :*

Dr. B. R. Hegde.

*Representative to the Central Council :*

Dr. U. P. Mallya.

*Representatives to the State Council :*

Dr. M. Umesha Rao.
Dr. K. Nagappa Alva.
Dr. K. B. Shetty.
Dr. U. P. Mallya
Dr. B. R. Hegde.
Dr. (Miss) L. Colaco.

*Executive Committee Members :*

Dr. A. F. Coelho.
Dr. U. P. Mallya.
Dr. K. Krishna Bhat.
Dr. M. D. Adappa.
Dr. K. B. Shetty.
Dr. A. Thimmappayya.
Dr. M. Umesh Rao.
Dr. B. G. Baliga.
Dr. M. G. R. Sampigethaya
Dr. S. N. Alekal
Dr. H. Venkatramanaya.
Dr. K. Narayan Nayak.

Dr. S. S. Ugrankar, MD, MRCP, (Lond.) of Bombay gave a learned discourse on " Specialisation in Medicine—Its Uses and Limitations ".

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